The Journal

OF

The Kansas Medical Society

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Ethics.—Dr. Hart's article on ethics in this issue preaches us a good sermon. We must do unto others as we would that they would do unto us. Now here as everywhere else in life it is the spirit rather than the letter that enlivens. Hence the "code" caused more trouble than good and had to be superseded by something which sought to install principles rather than define practices. The whole matter of ethics lies in the feeling of one toward his fellows. If this feeling be kindly, one can both "give and take" patients and patronage without any bitterness. If, however, a physician is seeking greater prestige or income and would like to be alone in the field, his annoyance at the presence of others cannot but find expression in word or deed. Such a man as the latter would be most punctillious in his observance of the regulations of the code—and yet would be a most vexatious neighbor. Such a man gives rise to the lay ridicule of the "Alphonse and Gaston" practices among physicians. Thus recently the Kansas City Star devoted some time to the discussion of the absurdity of medical ethics because at the theater a woman fainted, was carried to an ante room and a physician across the way summoned. Before he arrived an attendant spied another physician in the audience and called him out. The two physicians arrived at prac-

tically the same moment. Each bowed low and asked the other to take the case "It is your case, my dear Alphonse," "No, it is yours, dear Gaston." Meanwhile the patient remained unconscious. The disgusted manager of the theatre ejaculated, "Here, Dr. ——, you take this case. I will be responsible for your pay." Now if the right feeling had prevailed both physicians would have gone to work and revived the woman and given the case finally to her medical regular attendant.

The Practical Lesson from all this is that we must keep in closer touch with each other. We must know each other better. We must meet our colleagues frequently enough to be on good terms with them. Possibly a social evening now and then, possibly the professional discussion of a medical society meeting will do it. But, however, it be done, its doing spells organization. In big towns, in hamlets, or in the sparsely settled short grass country, let there be organization.

The New Pharmacopeia.*—The JOURNAL is in receipt of a copy of the eighth decennial revision of the Pharmacopeia of the United States. It is a cloth bound octavo volume of 692 plus lxxv pages. Of these 513 pages are occupied by the pharmacopeia proper. An appendix of 121 pages contains tables, tests, reactions, etc. The index which is very complete occupies 55 pages. The preface and introduction occupy the lxxv pages. The committee has introduced some 129 titles among which we notice the following active principles—thus meeting to some extent the demand for active principle medication on the part of the younger physicians: acontina, cocaina, codeina, phos. et sulf, colchicina, hydrastina, pelleterinae, tannas, pilocarpinae nitras, scopolaminae hybrabromidum, strophathinum, strychninae nitras. We are grateful for this much because we know that by the time the next revision is made digitalin, arbutin, cicutine, aspidospermine, agaricin, and perhaps a dozen others will have come into such general use that the Pharmacopeia cannot refuse them recognition.

Every Prescribing Physician should have the Pharmacopeia at his elbow, because it will prevent the blunders which now disgrace our profession. In fact the writer believes that it will lead to the use of more standard drugs and fewer proprietaries. The reason why many of us prescribe proprietaries is that in a "pinch." we remember the advertising pages in our journals better than the drugs in our materia medica. Again the Pharmacopeia will demonstrate to us that we can save our patients

*THE PHARMACOPEIA OF THE UNITED STATES OF AMERICA—Eighth decennial revision,—by authority of the United States Pharmacopeial Convention held at Washington, A. D., 1900. Revised by the Board of Revision and published by the Board of Trustees. Official from September 1, 905. Philadelphia: P. Blakiston's Son & Company. (A notice of this work appeared in the August JOURNAL.)

money by ordering standard (and stock) drugs instead of the more costly proprietaries. In this connection we call attention to the cataplasma kaolini and emulsum olei morrhuae cum hypophosphitibus. In these two cases the physician must decide whether it is better to order a preparation made by some large house or ask druggists to make up a preparation specially for him. Here one's confidence in the druggist must decide, rather than the fear of using proprietaries. What we want is the best and most dependable drug,—and when some chemist makes a business of putting out a standard, we are inclined to favor him.

Materia Medica and Therapeutics.—In these days of therapeutic nihilism and general scepticism the lack of positive information as to the character and action of drugs is becoming not only noticeable but even hurtful. The advance in positive knowledge of physiologic processes has unsettled our traditional beliefs in therapeutics and the most of us are grasping at straws in our wild efforts to secure a firm hold on something secure. All our knowledge of drugs has had to be revised and new data is being published daily. Hence the difficulty in finding authoritative teachings on the subject and the chaotic condition of the recent graduate's repertory of remedies . It is therefore small wonder that the physiological therapeutist outdoes his drug-giving brethren in enthusiasm. It seems time that more systematic work be done along this line,—and we hope that more work will be done than ever before because of the drubbing our lazy brethren who are using proprietaries are receiving just now. This work should be centered in two places: (1) in the county society and (2) in the schools of medicine. For the first no more profitable exercise could be indulged in than the discussion of the physiologic and therapeutic effects seen by the various members in the use of individual drugs. When these reports are compared with those of the text books, there is usually food for much valuable thought. In the schools it has been difficult to secure teachers who actually know both the therapeutic effects of drugs and also the methods of preparing those drugs. We have depended on the pharmacist and physiologist altogether too much, men who know only the laboratory side of the matter. This work should be of sufficient importance to be in the hands of physicians who can check up theory and animal experiment by real sick room experience, and since the realization of a need brings the filling of that need, we are hoping for more definite teachings in our schools. We have been led to this discussion by the receipt of a copy of the new edition of Professor Sayre's

*Organic Materia Medica,—a revision made necessary by the changes of the new pharmacopeia. Professor Sayre has presented his side of his subject remarkably well; we could only wish as we read the book that he had a collaborator to work out (so far as is known) the physiological and therapeutic uses of the drugs described. If one should take now Shoemakers' or Butler's text on drugs and use it with Professor Sayre's on the source and pharmacal characters of the drugs the physicians would have a good reference book on therapeutic agents—provided the Shoemaker or Buther were entirely satisfactory and up-to-date. Professor Sayre's book has been much improved in this edition by the work of his assistants, Messrs. Havenhill and Sterling, and we congratulate Professor Sayre on the success and popularity of the treatise. Professor Stevens' study of plant histology which occupies some 110 pages of the book makes it of much greater value to pharmacists and those who have to study the composition of drug plants.

In Minnesota the State University has a strong department of medicine. This department comprises (1) The College of Medicine and Surgery, (2) The College of Homeopathic Medicine and Surgery, (3) The College of Dentistry and (4) The College of Pharmacy. The department is resident in four buildings situated upon the University campus: viz: Medical hall, the laboratory of Medical Science, the laboratory of chemistry, and the laboratory of anatomy. The laboratory of the state board of health is located in the medical building. The clinical building is out in the city and is a two story building 40x150 feet.

In Kansas we have a school of pharmacy and a school of medicine. The laboratories are located in three buildings on the University campus—Medical hall, Snow hall, and the Chemistry building. The Clinical building has not yet been erected but will of course be in Kansas City. However, we have not cited Minnesota to prove anything beyond the practicability of the combination (1) of dentistry and medicine and (2) of the board of health laboratory with the University laboratories. How many of our Kansas dentists favor making dentistry a part of the medical course?

*A MANUAL OF ORGANIC MATERIA MEDICA AND PHARMACOGNOSY: an introduction to the study of the vegetable kingdom and the vegetable and animal drugs, comprising the botanical and physical characteristics, source, constituents, pharmacopoeial preparations, insects injurious to drugs, and pharmacal botany, by LUCIUS E. SAYRE, B. S., Ph. M., Dean of the School of Pharmacy of the University of Kansas. Third edition, revised. With histology and microl technique by WILLIAM C. STEVENS, Professor of Botany in the University of Kansas. Pp. 692, 8 vo. boards (cloth). 347 illustrations, Philadelphia: P. Blakiston's Son & Co. 1905.

A Criticism—"The Journal of the Kansas City Medical Society, not content with printing large display ads for the Antikamnia Chemical Company, must put in a supplement in their last issue setting forth its advantages. This is more glaring than all the rest and shows the need the Journal has for money. Since the Journal receives but one dollar from each member of the Kanasas State Medical Society it is absolutely necessary that funds be raised in some manner; at any rate it must appear so to the manager of the Journal."—The Wyandotte County Medical Journal.

No doubt in spite of the blunder in the title our JOURNAL is intended in the above paragraph. We are glad that the brethren in Wyandotte county are so without sin that they can cast stones. Nevertheless we take the criticism in good part and will state that if the physicians in Wyandotte county will give up their Journal and turn in and increase the circulation of our JOURNAL, and if the Kansas Medical Society will authorize it, we will gladly cut out any and all advertisements that offend the refined gustatory sense of our critics. However, in a recent investigation of the matter we found that most of the physicians interested in our society used all the articles advertised in our JOURNAL. A stream of water can not rise higher than its origin, nor a society Journal higher than the leaders in its society.

Proprietary Medicines.—"The patent medicine evil should be assailed, but the proprietary nostrum must first be eradicated. Before we can proclaim war on patent medicines, with energy and with a clear conscience, it will be necessary for us as physicians to rid ourseles of the proprietary nostrum evil by ceasing to prescribe preparations that are nothing more nor less than patent medicines. Before medical journals can criticize newspapers for carrying patent-medicine advertisements, they must themselves refuse advertisements of similar preparations, even though these be dignified with the name of proprietary medicines. THE JOURNAL of the American Medical Association itself is not yet entirely free from this reproach, but it is freeing itself as rapidly as undesirable contracts expire.—The Journal of the A. M. A., Sept. 9, 1905.

What shall Kansas do about it?

PARABLE NO. III.—FROM THE BOOK OF ETHICS.

THOMAS ESCULAPIUS.

From the Texas State Journal of Medicine.

And there came to a certain Town a youthful Leech, fresh from a great City. Upon his Wall he hung the Skin of an exclusive Temple of Chirurgery and upon his Raiment shone the Pin of the Eta Pi Society.

For many days did he rise up and bow down in the pursuit of Success and in publishing himself in the town Papyrus and criticizing the back-number Leeches in his Neighborhood. But Recognition dallied and Fortune stirred not.

Then said a Leech across the way, "What Blows are these I hear?" and another, "Whence these Noisy Strokes?" and a Neighbor, "Wherefore the Tappings in thy Rooms?" and a Patient, "Why these Rappings about thee?" But the Leech could not perceive, and said unto himself, "Am I possessed or diseased, that I can not hear?"

Then sought he an Aged Leech, whose Hair had whitened in the service of Love, and desired to know what Humor beset him. And when the Aged one had listened, he said, "My Son, I perceive thou has the Malady of youth-acute Knockorrhœa. Mercury for the Bile, Sorrow for Tears and Humility for the flow of Human Kindness."

And the Young Man joined the Eta Humble Pi Society, and the Aged Leech, looking upon him, loved him and said to himself, "Verily, our Deeds are a Discharge of the Heart and Success itself is a Secretion." Selah.

MEDICAL ETHICS FROM ONE VIEW POINT.*

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The principles which the members of the medical profession have voluntarily established for their guidance are the most unselfish known in all human affairs. The code of the profession is but an amplification of the golden rule, to which is added, "And love your neighbor (that is every human being) as yourself." It is the only profession, trade or occupation the followers of which bind themselves not to seek personal advantage in any invention or discovery they may make. That is, when a physician succeeds in elaborating a new remedy or combination he is in honor bound to make it known to his professional brethren, that the patients of other physicians the world over may enjoy its benefits. This explains one reason for the intense hatred of all honorable physicians towards the proprietary and patent medicine business;—it is so essentially selfish in its nature. Thus the socialistic principle of the medical profession, "As freely as you have received from all, so freely give to all." And

*Read before the Kansas Medical Society at Wichita, May, 1905.

to this extent humanity is benefitted, and the advancement of this science greatly accelerated. Medicine in all ages, has attracted into its ranks the most self-sacrificing members of society. As a science it was born in altruism. To this day it offers the greatest opportunities for the practice of the ennobling of character. Medical men stand alone on the earth among all others, striving to extinguish their own business. They preach temperance, virtue and cleanliness, knowing well that, when people come to follow their advice, their occupation, like Othello's, will be gone. They establish boards of health, well knowing that all sanitary measures keep money from their own pockets.

In producing a paper on the subject of "medical ethics" it could be greatly abbreviated by simply enumerating all the virtues in the whole catalogue of virtues and then say, "Follow these." Then we might mention all the vices and say, "Do not practice these." But after all this we might say that we were not acquainted with any code of medical ethics and in fact we may never have seen a copy of any "code" yet we have with us in memory, the old, old civil code, "Do unto others as you would that they should do unto you." which is a sure and very safe guide, for he who is desirous of being a true ethical, medical gentleman, need never fail, in a true conception of the right. You, and every true physician among us, owes his sacred allegiance to it and the American Medical Code adopted in 1847, which from then until now has governed and instructed our profession throughout this broad land, protecting the good and restraining the bad, just as the commandment of Holy Writ, above quoted, has restrained and instructed mankind in past ages. You and all other physicians are supposed to have studied this code and to be familiar with its requirements. The moral claim which it has upon you rests not upon any obligation of personal friendship toward your professional brethren, but upon the fact that it provides for every relation, contingency, and occasion, and is founded on the broad basis of justice and equal rights to every member of the profession. Its precepts can never become useless till a regenerate and infallible human nature makes both codes and commandments unnecessary. It is the great oracle of right and reason, to which we can resort and study the moral aspect of all the subjects that are likely to confront us from time to time, and no better code of moral principles can be found anywhere. To this lofty code, in a great measure, is due the binding together and elevation, far above the ordinary vocations, of the medical profession of our land, and the esteem and honorable standing which it everywhere enjoys.

By its dignity and justice it remains as fresh and useful today as when the profession adopted it, more than fifty years ago, and if you

faithfully observe its teachings you can truthfully exclaim, "I feel within me a peace above all earthly dignities, a clear and quiet concience.

Professional morals are an important part of Medical Education and training, and as much the duty of every medical college in America to acquaint its students with the precepts of the code of ethics of the American Medical Association, and to furnish to each of its alumni a copy of it with his diploma, as it is for a mother to familiarize her children with the Ten Commandments. If in the struggle and competition for practice you desire to act unfairly toward your brethren, the code will compell you to do the evil biddings of your heart in stealth or not do so at all.

Any one upon whom you encroach will feel himself justified in retaliating with your own weapons in like manner, and you will reap a crop similar to the seed sown. When called to attend a case previously under the care of another physician, especially if the patients and friends are dissatisfied with the treatment, or if the case is likely to prove fatal, be careful and just. Do not disparage the previous attendant by expressing a wish that you had been called in sooner, or criticize his conduct or his remedies; to do so is mean and cowardly in either case. Even if he has erred in any way, in all such cases do not fail to reply, to the questions of the patient or his inquiring friends, that your duty is with the present and future, not with the past. We should inform ourselves as best we can as to what line of treatment has been followed in the case, but refuse to either examine or criticize the previous attendant's remedies. Let our conversation also refer strictly to the present and future and not to the past, and in no way allude to the physician superseded, unless we can speak clearly to his advantage. As a rule, the less we say about the previous treatment, the better. To take a mean advantage of any one whom you have superseded, besides being morally wrong, might engender a professional hornet, which in retaliation, would watch with a malignant eye and sting fiercely whenever opportunity offered.

Let courtesy, truth and justice mark every step in your professional career. Seek, moreover, to defend your profession in public esteem on every fitting opportunity, and defend your brethren and your profession, also, when either are unjustly assailed. Indeed, to fail to defend the reputation of an absent professional brother, even by a conspiracy of silence, when justice demands you to speak, is not only unprofessional, but is more or less dishonorable, and implies a quasi-sanction of the libel. Every physician has his successes, and also his failures. Where you are highly successful in diagnosis, or have worked wonders in treatment after others have failed, observe a proper degree of modesty. and avoid pushing your triumph so far as to wound the feelings or mortify the pride of your less successful predecessor. Take just credit, but be guided in

your words and actions, and take no undue advantage of their errors, that you may not in turn invite disparagement or arouse hatred. No man likes to be surpassed by men of his own level. We all know there are a thousand unwritten ways to show an ethical spirit and a thousand indefinable ways to evince an unethical one. When you doubt whether this or that patient is fairly yours or another, give your rival the benefit of the doubt. Never be tenacious of doubtful rights, but let your every day conduct, in this and all other respects, entitle you to the esteem of your medical neighbor.

Yet, while alive to your own interests, you should not captiously follow up every trifling ethical infringement, difficulty, or apparent contradiction, as if you were ever on the watch for provocations and angry collision with your neighbors, and courted a war with everybody for what you may be pleased to call your "rights." A certain amount of jarring and clashing in a profession like ours is unavoidable: Allow liberally for this; school your feelings; bury pettiness and narrowness, and maintain a friendly attitude toward all fairly-disposed neighboring physicians. Unless you do so, many questions will arise that can not well be adjusted by an appeal to the code, and you will become involved in useless, rancorous, and endless controversies and reprisals with those whose paths may happen to cross yours own. If ever you have cause to believe a medical neighbor has treated you unfairly, or misconstrued your own conduct or motive, instead of the fierce onslaught and bitter rejoiner, go or send directly to him, and in an earnest but urbane manner make or ask an explanation; for whenever two persons have a disagreement they do not understand each other or they have honest but different viewpoints, or, one or the other or both are not honest in their motive.

Be very careful not unjustly to encroach on any other physician's practice; also, never attempt unjustly to retain any patient to whom you are called in an emergency; if you are in doubt whether you were deliberately chosen, or only taken in the emergency, do not hide yourself behind a mean technicality of ethics, ask the direct question, "Am I your choice in this case?" If you learn that another was really preferred to you, surrender your patient to him on his arrival, even though you may be for politeness' sake asked to continue in attendance. Circumstances may even require you to have the former attendant sent for in a case, either to take charge of it or for consultation. Acts of neighborly kindness are frequently performed by physicians for one another, and go far, very far, toward neutralizing the ruffles, stings, and collisions of interests which the very nature of our profession makes inevitable. If our conduct toward other physicians at such times is invariably just and honorable, as if rising from a simple desire to do that only which is right, it will

in due time be recognized and appreciated, and will not only assist in making our road pleasant, but, if we unwittingly infringe, one and all will acquit us of any intentional error. When you are called, in an emergency, to prescribe for a patient who is under the care of another physician, it is better to leave for him a copy of your prescription, that he, knowing its exact character, may be able to judge whether or not he should continue its use.

Let it be your invariable rule never to visit a patient who is under the care of a brother physician, as a "smelling committee" or medical detective for the patient's beneficial society, with a view to ascertain, if he be malingering, or for an employer, friend, or relative who is anxious and apprehensive in regard to his illness, or for one in fear of an impending damage-suit, with a view to report thereon, without the distinct sanction of the attending physician. It would be still greater wrong to clandestinely remove the bandages from fractures, dislocations, ulcers, etc, applied by another physician, whether it be to change treatment or merely to examine the case; but if the emergency of the case seemingly demands it, notify the physician who applied it at your earliest convenience, giving your explicit reason for so doing. We should be also extremely discreet and chary of visiting patients under the care and treatment of other physicians, even for social purposes, as it is a frequent cause of suspicion and contention. Never take charge of a patient recently under the care of any regular and ethical physician without first ascertaining that he has been formally and duly notified of the change. The principle that governs such cases is this: When a person is taken ill he is at liberty to select any physician he prefers, but after making a selection, and when the case has been taken charge of, if for any reason whatever the patient wants to change, he must, in doing so, follow the established custom, for if there are any hard thoughts against the other physician, or unpleasant scenes with him, the patient and his friends should have them, not you.

The dissatisfied persons who wish to discharge their medical attendant and employ you, will sometimes contend that the rules relative to taking charge of patients, recently under care of another physician, are harsh and unjust, and peculiar to the medical profession. Neither of these statements is true, for our custom is identical with that which prevails every where among all classes of people, which requires the formal discharge of the old employe before a new one can take his place. Besides, no person, whether menial, mechanic, or physician, can fill a vacancy till one exists

Be especially chary of taking cases in families into which you have been called in consultation more particularly if you were called at the

former attendant's suggestion, on account of your supposed merits, for he, chagrined at his displacement, will be apt to scan every feature of the change, and, if there be any ground at all for suspicion, he will conclude that instead of obeying the Golden Rule, and sternly refusing to supplant him, you have taken advantage of the introduction he gave you, ingratiated yourself in, and ungenerously elbowed him out. And remember this, that the profession will instinctively soon learn who is fair, honorable, gentlemanly and ethical, and who is above taking advantage of these unfair opportunities and call him in all consultations, or in their absence from home or indisposition from professional duties put him in charge of their practice, fearing no mean or under-hand scheming.

You will sometimes be called to a patient, and, upon going, will find that he is under the care of some other physician, and will, of course, refuse to attend, but you will almost surely be urged to just look at the patient and tell what you think; or whether the attending physician's treatment is not wrong; or prescribe for him; with the assurance that the other physician shall be kept in ignorance of your visit. Bear in mind that honor and duty require you to do right in these and all other positions, in which you may be placed; not through fear, or for policy's sake, but because it is right to be right, and for the other equally broad reason that you yourself would be cognizant of the wrong, whether the other knew it or not, and it would lower you in your own eyes; decline, therefore, courteously but firmly, their solicitations, with an impressive assurance that you desire to possess your own respect as earnestly as you do that of others.

Unless a great emergency exists, you should determinedly refuse either to sit in judgment on another's work, or in any way to interfere; if, however, the case be one of urgency, your services should be rendered for the atending physician, and you should leave a note telling him what you have done, or see him in person if possible and do the same. Be careful to do every preson justice. Suffer injustice rather than participate in it. Sometimes, even though the letter of ethics allows you to take a patient, it may be unwise or unkind to do so; use such opportunities to harmonize, rather than to disrupt. You can do this, yet not make a habit of cheating yourself out of patients.

So, finally, I would say every remember the code of medical ethics and live as closely to its precepts and spirit as possible; and, never forget every principle of honor and duty requires us to stand by and defend each other in every thing that is reasonable and just, and forbids us to think of lending ourselves as "medical cat's paws" in malpractice suits or otherwise. Remember that the absence of rules for our government would also leave Dr. Allforself and others to frame their own codes,

which might violate all logic and rules of propriety, as is often done in violation of ethics and the Golden Rule. The non-existence of a code of ethics would also make it possible for Dr. A. to pounce on the patients of Dr. B., and carry on a regular system of infringements, self-advertising, certificate-giving, and wrong-doing in general, regardless of their rights and still claim that they were as honorable as SOCRATES, and there would be no visible standard of appeal by which to prove the contrary. In view of these and many other facts it has been found necessary to have a written code of ehtics for regulating the conduct of physicians toward each other.

SOME NOTES ON GENERAL ANAESTHESIA.*

DR. F. L. ABBEY,
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The subject of General Anaesthesia has never received the attention it deserves. The wonderful achievements and great advances of surgery in recent years have attracted the admiration and fired the ambitions of modern surgeons. With steady hand and dauntless courage they have explored almost every nook and corner of the human body, repairing injuries, removing diseased organs or abnormal growths and correcting deformities. Great credit has been given to Asepsis and Antisepsis for these great advances in Surgery. Shall we not give equal credit to Anaesthesia without which these great operations can not be performed? Ask the patients who have survived serious operations what was their greatest dread as they approached the operating table, the operation, or the anaesthesia. Four out of five of them will say, "The anaesthetic." Why? Because they know that as they close their eyes to this artificial sleep they are giving up will, consciousness, all their special senses, power of motion and sensation. They are dead to all the world and only the breathing and the pulse give sign of life. When fully anaesthetized they are close to the boundary line between life and death, and who shall say how far they may safely go. A little further and respiration is impeded or

*Read before the Kansas Medical Society at Wichita, May, 1905.

suspended and last of all the heart ceases to beat and life departs. Is it strange that patients who are enfeebled by injury or disease, to whom the result of the operation may mean life or death, are fearful to yield themselves to the sleep that may be their last? Have they not a right to ask that the man who holds the slender thread of life in his hands in this way shall be as skilled as the one who yields the knife and needle? In this connection allow me to quote the general conclusion of the Anaesthetics Committee of the British Medical Association from their study of over 25,000 cases. "By far the most important factor in the safe administration of anaesthetics is the experince of the administrator. In many cases the anaesthetization completely transcends the operation in gravity and importance and to insure success particularly in these cases it is absolutely essential that an anaesthetist of large experience should conduct the administration."

What are the facts? Many of the patients who are operated upon are anaesthetized by men whose whole course of instruction in anaesthesia consisted in listening to one, two or three lectures on that subject given by the lecturer on general surgery whose own experience was that of an operator and not that of an anaesthetist. True, our medical students see ether and chloroform administered at the hospitals but the interest of the class is centered upon the operation. If the patient lives great is the credit to the operator. If the patient dies on the table, the anaesthetic was the cause of it. But few schools give adequate special instruction and demonstration in anaesthesia. Didactic lectures and text books are not to be relied upon to produce expert anaesthetists any more than correspondence courses are to make expert stenographers.

It is true, especially in country practice, that emergencies often arise and necessity compels the employment of an inexperienced physician or even one who is not a physician. But whenever possible the services of a competent anaesthetist should be secured.

It is unsafe to take the patient's word as to the condition of the stomach. Patients have declared that they have not taken food for hours, and yet under anaesthesia have yielded up chunks of banana, cheese, oysters, gum drops and hard boiled eggs. These are a serious menace to the life of the patient on account of the danger of their entering the trachea. It is also well to make it a part of the routine to see that there are no false teeth or other loose articles in the mouth. The best position for a patient is the horizontal one. If a pillow is used it should be a low one and placed under the shoulders. In this way the head is slightly over-extended and the face should be turned slightly to one side, usually to the opposite side from the operator. This position causes the least embarrassment to the respiration and gives ease of control. If the lower jaw drops and hinders

free breathing is should be supported, but the practice of forcibly dislocating the jaw forward is rarely necessary. The posture of the patient should be as natural and comfortable as possible always keeping in mind that paralysis from pressure, dislocations from careless handling and even fractures may be suffered by a person while anaesthteized. Care must be taken when the patient is taken from the warm operating room to avoid sudden chilling in cold halls or by open doors and windows. Sudden jolting or jarring of a patient just recovering from deep anaesthesia or bordering on surgical shock may be immediately fatal. The patient should be without a pillow in a warm bed, arms, limbs and head comfortably disposed, and a nurse in constant attendance until well awake. Hot water bottles should never be in immediate contact with the patient's skin, which might be seriously burned while the patient is still unconscious.

The anaesthetist should never crowd the anaesthetic. Especially is this true in the early stages of anaesthesia. Crowding the anaesthetic upon a conscious or semi-conscious patient means resistance and struggling and a struggling patient is in danger. He may in one or two deep inspirations receive an overwhelming dose of concentrated vapor and die before completely anaesthized, though it is not an overdose necessarily that kills, but the concentration of the vapor by exclusion of air. Surgeons are usually busy men and when prepared for the work before them are anxious to get it done as soon as possible. But the safety of the patient is the prime consideration before which all others must yield. Forcing a mask or cone saturated with the anaesthetic upon the face of a half conscious being, weakened by disease and half crazed by fright and worry, and excluding air and forcibly restraining the patients efforts to get away, simply because the surgeon is waiting and has another engagement, is neither right nor safe. Statistics and experience teach us that a large percentage of deaths from anaesthesia are in the early stage of the administration These are due to three causes: First, the crowding of the anaesthetic; second, the limitation of air, third, shock under imperfect anaesthesia.

The confidence of the patient should be secured as far as possible—assurances of careful attention and of trust in the ability of the patient to take the anaesthetic well; and warnings of what may be expected as a matter of course, such as the bad odor, choking sensations, numb extremities and noises in the ears should be given. The room should be quiet, free from the bustle of preparation by nurses and operators. Talking and laughing during the early stages are likely to be misunderstood and mis-interpreted by the patient and should not be indulged in. It is best to have the patient well under before beginning even the final preparation

of the operation field, especially about sensitive parts as the rectum or perineum.

I will not enumerate the signs of complete anaesthesia, signs of danger, etc. No one sign by itself is infallible. A dilated pupil may be a sign of an over dose, or in a neurotic subject may be a reflex from the operation. Light breathing may be the sign of approaching collapse, or it may signify too light anaesthesia. A rapid pulse may mean failing heart, or precede the vomiting of waking. Half open eyes are usually a sign of a poor subject; but I have known such who presented no other unfavorable symptom. In operations requiring profound anaesthesia the conjunctival and corneal reflexes are sometimes wholly abolished. I would not disparage the observance of these signs but there is besides these a general picture of poor condition that notifies the careful anaesthetist that all is not well with his patient. It is not easy to describe but is probably a composite of unfavorable symptoms and the early recognition of it may save the life of a patient when dependence upon the appearance of one or two special signs may prove fatal.

I believe in simplicity in methods and apparatus. An Esmarch inhaler is light, cleanly and furnishes ample opportunity for the admixture of air and the distribution of vapor. With a common bottle fitted with a properly notched cork the amount of anaesthetic can be regulated at will. The complicated closed inhalers with valves, tubes, air chambers, ether bags, and foot pumps are cumbersome, unsanitary, out of order and unsafe except in the hands of their inventors or those who have had long experience with them. They may save material but are costly themselves. They may be impressive, but carry disease germs from one patient to another. Except in expert hands they are dangerous to the life of the patient, which in itself is enough to condemn them.

Less than a year ago the statement was made by one of our members who had spent some months in the hospitals of Europe, that ether was being given very extensively upon an inhaler of the Esmarch style. I have tried it many times since and I am very much pleased with it. I usually begin the anaesthesia with a cautious, carful slow administration of chloroform. When consciousness is lost I change to ether without changing the mask and the patients enters the surgical degree without having struggled, without embarrassment of breahing, without excitement, but stimulated, vigorous and full of life. And I am able to keep them under, to prevent vomiting and to have less trouble and more satisfactory results than with an Allis or even more complicated inhalers.

The accidents of an aneasthesia are better prevented than treated at the time. The careful preparation of the patient, attention to the stomach and bowels, examination of urine, and the administration of

strychnia for several days previous to the operation will aid materially as preventive measures. In sudden complete collapse it is best to throw the feet down and head up for a few seconds to empty the distended heart,—then the head down position while artificial respiration by Sylvester's method is continuously employed. In beginning artificial respiration in these cases, the first maneuver should be to compress the chest to empty the heart and to force out the surcharged air from the lungs. If the arms are first extended above the head the heart is further distended. Rythmic traction of the tongue has seemed to be of great benefit in some cases. In cases of shock during or after operation I have seen the most favorable results form the use of salt solution in the veins.

DISCUSSION.

Dr. Hutchison thought that it was not always best to take the word of the patient as to whether there was anything in the mouth or not, but that it was always best to make sure by examining ;he encountered a case in his own experience, of a child who assured him that there was nothing in the mouth. Some trouble occurred, mask was removed, and a pin was taken from her mouth.

Dr. Longenecker said that he could not see the exact reason for administering strychnine two or three days before operation, that the effect was transient and need only be given immediately before administration of anaesthetic.

Dr. McGuire.—It seems to me that this is an important subject, and should be discussed more by the general practitioner. It is well to talk over the various methods of giving. Some are fortunate enough to be situated in such a way as to have some one give the anaesthetic for them, while others are not. Certainly a brilliant operation with bad administration of the anaesthetic does not give very brilliant results. The routine practice with some men is to give patient small doses of strychnine a few days before operation. The continued stimulation before anaesthesia has given us best results. Above everything else, an intelligent knowledge of what the kidneys is doing before the operation, is the most important I have seen fatal terminations by the kidney route following chloroform, but I do not say that it was the chloroform that killed. Your case should be absolutely protected with blankets and carefully watched for the first twelve hours, or you may have grave danger with your kidney. This is absolutely necessary for at least twelve hours after administration of anaesthetic.

Dr. Schenck said that he would like to ask a few questions. One was as to the relative safety of mixed anaesthesia,—whether to give one first,

following immediately with the other, or, whether it would be better to give them mixed? Another was, as to the advantage or disadvantage of giving morphine before administration of anaesthetic? The doctor remarked that it was not always possible to have patients in an ideal position or condition, and told of a case in his own experience of a boy, who immediately after a very hearty dinner, consisting principally of green corn (as the doctor could prove) was thrown from his horse and had an arm broken, Not an ideal condition upon which to administer an anaesthetic, —but the patient recovered,—his corn!

DR. FABRIQUE—There has always been a good deal of controversy as to the relative safety of the two anaesthetics. I do not believe that chloroform is as dangerous as many surgeons would have us believe, nor that ether is as innocent as some have credited it with being. Nor do I believe that every case of renal complication following operation is due to the anaesthetic. Disturbance of the nerve ganglia of the abdomen is as apt to produce trouble as the anaesthetic. I have always used chloroform exclusively; Dr. Bowers has for the past two or three years used ether exclusively. We always examine urine before and after operation, and thus far have found no difference in the effects occasioned by the two. It seems to me that there is less vomiting after chloroform, but I believe that the majority prefer ether. We hear of a good many deaths by the "kidney route" when many times I believe the anaestheitc had nothing to do with it.

A MEMBER:—I think it very important to give chloroform first, and then follow up with ether. It is a very bad suggestion to instruct the patient to "breathe deeply." Secure the confidence of your patient, and give gently, having him breathe naturally until lungs get used to the change then you can push it w thout danger.

DR. RILEY said that if we would make ourselves conversant with the condition of the blood, and the changes likely to take place therein, we would have less trouble with the kidney post-operative.

DR. HERTZLER spoke of the importance of haemaglobin estimate of blood, that the great reduction of this constituent of the blood was not sufficiently taken into account; it might show 45 before operation, and after operation but 25. He thinks ether safer than chloroform, but that chloroform was dangerous because improperly given; spoke of a case in which incision was made before patient was thoroughly under. Patient drew quick breath, thus inhaling a very concentrated form of vapor, with fatal result.

DR. HALDERMAN spoke of the different effects which an anaesthetic might produce upon the same individual at different times, and men-

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tioned a characteristic case: Patient with crushed foot; went quietly and smoothly under, with no trouble, and no unpleasant effect. Two or three weeks later had occasion to use anaesthetic again, administered by the same anaesthetist, at the same time of day, and with same conditions existing,—but he took is very badly all the way through, and suffered the greatest nausea and distress for 45 hours afterward.

DR. ROSS spoke of the utility of "Narcotine" in dental work, as well as for opening of abscesses, curettage, etc. It is transient in its effects no nausea, and very little systemic disturbance following its use.

DR. MUNN spoke of the use of spinal cocainization, and said he did not see why this method should not become more popular, as the technique was simple and results satisfactory. He cited a recent case which he saw in which the individual sat up and watched the operation, after having this method of anaesthesia used.

DR. GUNDRY thought that the administration of cocaine by spinal puncture was rather uncertain, as it was somewhat of an operation to get the needle into the proper place.

DR. ABBEY.—Strychnia seems to have a general tonic effect upon the patient. As to the effects being so transient, do not think the effects pass off as rapidly as stated. As to giving morphine, I do not believe in it because it is apt to obscure the effects of the anaesthetic. In regard to mixtures, my favorite is one part chloroform and three parts ether, have found it safe and easily given. There seems to be a difference of opinion as to urging patient to take deep inspirations. My idea is to secure the entire confidence of the patient; give him to understand that he will have some peculiar sensations; have him relax and make as little exertion as possible, and to breathe naturally and regularly. I do not think it necessary to keep urging to take a long breath. As to sudden death following operation there are various things which might cause it. The use of artificial respiration is very important, and should not be stopped too soon; it should be persisted in long, after the case seems hopeless. I know of many cases that have been resuscitated after being apparently lifeless for an hour, by a continued use of artificial respriation. In operating at night by lamplight, ether is very dangerous, because easily ignited. Chloroform is decomposed by open flame, producing a very irritating gas. You will not notice it very much if you have a closed stove, but in the presence of several lamps it will soon be made manifest.

THERAPEUTIC ACTION OF CHEMIC SALTS.

B. D. EASTMAN. M. D.
Professor of Materia Medica and Therapeutics in the Kansas Medical College.
Topeka, Kansas.

(Continued.)

PHYSIOLOGICAL ACTION.

In attempting to apply there physical processes of salt action to vital phenomena and to deduce therefrom therapeutic principles, we must distinguish between isotonic and anisotonic solutions, although the ultimate result will be much the same, notwithstanding it is brought about in different ways.

EFFECT UPON CELLS.

If the molecular contsitution of the medium surrounding the cells be changed, a change in the total water or salt content of the cells will result. A hyperisotonic change will withdraw water and a hypoisotonic change withdraw salts. If the ratio of the different salts in the surrounding medium is not the same as that in the cells, their ratio in the cells will be changed and when salts are withdrawn certain salts will leave more rapidly than others. A salt action on the cell will therefore result in the changing of its salt and water content and the ratio of individual salts. These changes will react upon the proteids just as in a test tube a certain increase of salt or water of a solution will precipitate globin or other proportions will disolve it. The physiological effect of these physical changes is irritation leading to quantitive or qualitative change of function. Metabolism is also changed, most pronounced in cells of lowest vitality and least resistance, that is, pathologic formation, chemical or anatomic.

A very strong salt solution injected into the circulation affects especially the central nervous system, causing stimulation and subsequent paralysis similar to effects of asphyxia. (This phenomenon explains at least in part, the sypmtoms of uremic poisoning, and offers the therapeutic suggestion of lessening the concentration of the blood by hypoisotonic sulution of blood salts.)

EFFECTS UPON SERUM.

The first action will be to increase the quantity of serum irrespective of the strength of the salt solution or manner of introduction. If an isotonic or hypoisotonic solution be introduced it will pass into the blood, obviously increasing the serum; if hyperisotonic it will be rendered isotonic by absorbtion of water from the tissues and then enter the blood. But the blood is prone to maintain its normal condition much more so than the

tissues and any attempt to alter its composition is met by discarding adventitions substances into the tissues where they remain until excreted. Hence, the composition of the tissues will be changed by salt action on the cells. The increased flow of blood will cause an increased flow of lymph, urine, sweat, and other liquid secretions by salt action, filtration and vital secretion, until the raito of serum to corpuscles becomes normal.

DIURESIS.

The introduction through any channel of diffusible substances into the circulation increases urine especially rich in the injected substance; but also holding increased amounts of the other ingredients. Inasmuch as urine is secreted against a practically non-proteid fluid, that is aganist urin, the vital activity of the cells is the most effective cause of such secretion. And as the introduction of any salt will cause an increased excretion of all other diffusible constituents of the cells, the result is a "flushing" of the whole body.

ABSORPTION OF EFFUSIONS.

Solutions of diffusible substances no matter of what concentration, are rapidly absorbed from any of the body cavities or cellular tissue. principally through osmosis. If the solutions are hypoisotonic, water will be absorbed from them until they become isotonic, if hypoisotonic they will first absorb water from the tissues until they become isotonic, then to be absorbed in either case. It might at first appear that the law of osmotic absorption of equimolecular salt solutions could not affect the absorption of effusions, which usually contain proteids, but the percentage of proteids is always less in them than in the serum and proteids outside the circulating body-liquids are gradually broken up into more diffusible compounds. The process though slow would still be complete, but filtration, secretion and other vital processes are doubtless concerned although the exact role of these different processes has not been determined.

ABSORPTION FROM THE ALIMENTARY CANAL.

Filtration and vital action are more concerned here. Water or salt will be absorbed until the contents of the bowel becomes isotonic, thus causing irritation which if mild, will stimulate functional activity and lead to increase of secretion, absorption and peristalsis.

THERAPEUTIC APPLICATION.

Water and hypoisotonic solutions will increase the amount of water in the tissues and remove salts from the cells. An experimental lilustraton of this action is the placing of lower organisms or some fishes in distilled water, where they lose their salts and soon die. Salt content cannot be safely lowered below a certain limit. It is not possible, however, to take distilled water into the stomach in sufficient quantities to remove salts.

from the body tissues in such amounts as to be injurious Absorption of aqueous liquids takes place very rapidly from the intestine but slowly from the stomach. Some experimental evidence is to the effect that water cannot be absorbed by the skin, although physiologists generally hold that it may be very slightly absorbed. Practically the epidermis appears to be almost impermeable to it. Bathing in cold water will contract cutaneous vessels, lessening loss from perspiration, hot water dilates vessels and favors diaphoresis

The excretion of water takes place by kidneys, lungs and skin . If administered with salts of urea it will ordinarily go with the latter and act as a diuretic. If given pure, especially if hot and with cardiac stimulants, it will act as a diaphoretic. When large quantities of water are taken the nitrogen in the urine is increased and vice-versa. Such increase of N. is doubtless largely due to the washing out of the tissue ready formed, diffusible nitrogen waste products. When the body is charged with a large amount of these, as in fever, chronic rheumatism, etc., water is valuable agent for their removal. If the consumption of water be kept high for a considerable time, the nitrogen excretion does not remain at its high level but does contiue higher than normal. An increased consumption of water may therefore be said to cause a breaking down of nitrogenous products, which like all salt action shows most strgngly on pathologic formations. This is the explanation of the action of certain weak mineral waters, and of the good effect of hot springs treatment.

These therapeutic uses all rest upon the alteration in metabolism, the increased secretion of urine, and sweat and excretion of nitrogen and other waste products. The result of this alternative action cannot always be foretold. If the breaking down of proteid materials be only partial, it may result in the formation of fat; if complete it may lead to the destruction of fat. Hence water or mild mineral water treatment may increase fat or may lessen obesity. But in rheumatism, gouty or uric acid conditions the free use of water is always beneficial. Indeed there are many persons, especially women who use too littile water to give the system that flushing out so necessary to the carrying away of effete matters. In acute idiopathic and symptomatic fevers and in almost all metabolic diseases, the free use of water, plain, carbonated, or slightly mineralized is of great benefit.

The indications for the use of water or hypersotonic solution as diuretics are the usual ones.

1. To remove liquid from body. Here the water in limited quantities should go with active diuretics.

2. The removal from the system of toxic substances, either introduced or indigenous. For this a free supply of water, reinforced with irritant,

salts, theobrominef piperizin, etc., is indicated. En eroclysis and hypodermolcysis of normal salt solution, are effective methods, too much neglected by the general practitioner

3. To dilute the urine, to render it less irritant, to prevent formation of calculi or concretions in the urinary tubules, or to dilute irritant poisons. As a diluent, water supported by throbromin is most useful .

The effect of watery baths of all kinds is due to an irritant action upon the epithelium, to reflex influence and to dilation or contraction of vessels and glands of skin.

It is important that soluble substances be given in dilute solutions when remote action is desired.

(To be continued.)

A CASE OF GONNORHEA WITH COMPLICATIONS.

DR. GEORGE R. WAITE.
Milan, Kansas.

Mr. Z. J. age 27, family history good, except that a brother had been troubled with hemorrhages. Patient had also suffered from internal piles for several years, passing large quantities of blood on defecation, with intense pain. These had been cured during the spring.

About six weeks ago patient consulted me regarding a urethral discharge, which from the history and symptoms I diagnosed as a case of gonorrhea, his first case. I prescribed protargol 2 per cent, solution and in six days discharge had ceased, having been very scanty all during the attack. About the fifth day after seeing the patient he began to complain of pain in the rectum. On making a digital examination I found the prostate gland enlarged to the size of a small apple, very hard and tender. I prescribed saw palmetto and santal oil, but the pain increased I tried milking the gland also but with the same result.

By this time (four days after patient began suffering pain) fever developed and I advised operation having diagnosed the case as one of prostatic abscess. On June 8 with the assistance of Dr. Owens, I inc's-

*Read before the Sumner County Society, June 29, 1905.

ed the perineum from one tuberosity of the ischium to the other, dissecting my way down to the capsule of the gland, which I cut into. There was but a small amount of discharge at the time I packed the cavity with iodoform gauze and dressed the wound with gauze and cotton, applying a "T" bandage. I called again to see the patient about one o'clock three hours after finishing the operation, and found the dressing soaked and wetting the bed clothes wet. I applied a new dressing and found it in the same condition as the first at 6 p. m. After changing the dressing again it was not necessary to dress the wound more than once a day, and in ten days the discharge had completely stopped, and the wound had nearly closed.

About a week after the operation patient again complained of pain in the rectum. This was due to eight external piles, which had formed a beautiful rosette around the border of the anus. I applied different salves, lotions, suppositories, etc., but with no effect until the pain was so intense that he could neither eat nor sleep without the use of morphine. After three days of suffering I told him we had better operate, to which he gladly consented. I used cocaine as a local anasthetic, incising four of the piles and expelling clots of blood, and excising and ligated the rest. After the effect of the operation had worn off the patient became easy and has steadily progressed to recovery.

As regards the local anesthesia: I have seen articles written recommending it for the removal of piles, but I am here to tell you as regards to the pain I might as well have used "Hot Air."

I would like to hear from my colleagues their opinion as to what size the prostate will attain during an acute attack such as this. I have seen cases before where the gland was considerably enlarged, but nothing comparable to this.

A KICK FROM A HORSE.*

F. M. OWENS, M. D.
Argonia, Kansas.

March 15, 1905 at three p. m., I was called to Benjamin Nicholson, a farmer, near Argonia, Kansas, aged seventy four, and found him sitting

*Read before the Sumner County Society, June 29, 1905.

up on the bed side supported by two persons, one on either side, breathing very heavily, suffering greatly from abdominal pain, and in a state of apparent collapse. As related by the hired man who was with him at the barn, I found that he had received a severe kick on the abdomen, slightly to the right of the median line, about eleven o'clock, or four hours before my arrival. Inspection showed plainly the prints of both hoofs. When kicked he was thrown violently to the ground, falling backward and to the left on left hip and sustaining an injury from which he still suffers. Within a few minutes Mr. N— arose, walked some distance to some corn fodder, thinking he was not seriously hurt, and began husking out the corn. This he continued for more than half an hour when the pain began in the abdomen with such severity that he called for help and was taken into his house. Upon my arrival his radial pulse was not perceptible; heart beat very feeble but regular; the bowels had moved copiously after the injury and before my arrival. A hypodermic injection of one-half grain morphia with one one-hundredth grain of atropine relieved his pain, restored his heart action, and recovery from primary shock began. I called twice daily thereafter, finding him in but little pain; heart action fairly good. This continued until Sunday, the 19th, when I found him upon my early visit in a condition from which I thought he could live but a few hours at most. The radial pulse was again imperceptible, the heart very weak and missing about every third beat, respiration difficult, skin cold and clammy. A cardiac stimulant was at once given (Dacosta's formula with strychnia) with but little response. Having previously arranged to take another patient to one of the Wichita Hospitals on Monday (the following day) I called in Dr. Waite of Milan to see the patient with me and care for him in my absence for the next two days. At my next call, about two p. m. (Dr. Waite being present) we found his condition somewhat improved. The return to the normal was gradual and slow from this secondary shock. The abdomen at this time presented a greatly distended condition and what appeared to be a large hematoma had formed in the lower right part of the abdomen. Mr. Nicholson's condition then seemed to improve for several days until the following Saturday when vomiting of fecal matter began and continued for almost a week. The bowels at this time were very inactive, almost paralyzed. On Wednesday, the 29th, I found him with a slight temperature and he complained of a pain in the upper thoracic region. Examination revealed an inflammation or pneumonia involving the upper right lobe. This went on through a typical course of red and gray hepatization with nothing unusual except a weak and feeble heart. The abdomen continued very much distended and the patient was troubled greatly with gas in both stomach and bowels, the colon tube being often

resorted to for relief. At about this time vomiting ceased and peristalsis was again set up, and the fecal matter moved downward. When the time arrived for resolution to take place in the diseased lung, I noted an evident increase in the amount of sputum, with a disagreable odor which grew worse daily and seemed likely to end the sufferings of my patient. Careful examination revealed the fact that necrosis of the diseased lung had taken place and the necrosed tissue was being raised in enormous quantities. The temperature at this time was subnormal and never had shown more than one hundred and one half degrees, Fahrenheit. The condition finally yielded to treatment and improvement began about May 20. Mr. Nicholson then began to get about the house; then trouble of a dropsical nature set up, the feet and lower limbs swelling until they were hard, glistening and very painful. This condition after defying for a long time the usual treatment exhibited in such cases, has at last yielded and Mr. Nicholson is now able to be about on his crutches with little or no swelling remaining.

Status praesens: Heart not strong, missing an occasional beat; appetite good; digestion fair; bowels sluggish. Urinary analysis shows no albumen or sugar. Patient is in fair spirits although he has lost many pounds of flesh.

PHYSIOLOGY.*

E. C. DUNCAN, M. D.
Fredonia, Kansas.

Human Physiology deals with living human beings in all their functional aspects, beginning with the beginning of life, next investigating its mechanism, tracing its growth to maturity, thence its decline and death. In the fifteenth century B. C. the Egyptians regarded hunger and thirst as quasi-poisonous substances within the body, requiring to be neutralized with food and drink. They considered that the heart increased in weight until the age of fifty years, it gradually diminished in size thereafter, until death ensued from its shrinking. Hippocrates says: "The source

*Read before the Wilson County Medical Society at its June meeting, Fredonia, Kansas.

of life is innate heat and is conveyed to all parts of the body by the pneuma which moves continually in the blood vessels. By the peculiar warmth of the stomach and adjacent organs food is digested. Blood in the right heart is cold whereas that in the left heart is warm. Blood is prepared in the liver which also prepares the bile. The brain condenses the ascending vapors into nasal mucus. How different are our conceptions of physiology today.

The first real progress began in the seventeenth century when Harvey demonstrated the circulation of the blood. Harvey failed, however, to make plain the passage of blood from arteries to veins, this part of the circulation, viz: the capillary, being described by Malpighi in 1661. In 1648 Van Helmont described fermentation in the stomach (the opinion being since the time of Hippocrates that it was the "peculiar warmth," etc., of the stomach that digested food) and during the next hundred years important work was done regarding the digestive tract. In the eighteenth century the gastric juice was first known. During this time respiration was receiving attention from Boyle and others. In the nineteenth century nearly all of our present knowledge of physiology was elaborated.

Physiology is one of the most important branches of medicine. It, with Anatomy, Pathology, Bacteriology and Chemistry form the very groundwork of all true progress in medicine. Without a knowledge of Physiology, the other fundamental branches of medicine are worthless for practical purposes, in fact they could never have reached their present state of perfection. Indeed Pathology would have been unknown. F. J. Lutz, Professor of Surgery in the Sims-Beaumont Medical College, ex-president Missouri State Medical State Society, etc., once said that he would rather trust the doctor who had a good up-to-date physiology in his library (its condition indicating that it was in constant use) than one who had all the works on surgery that were ever written and lacked the physiology. The blood is the most highly organized of the body tissues, it being composed of the elements which form all the other parts of the human anatomy. Hence a perfect knowledge of the blood is essential. One has but to compare Hippocrates' ideas of the blood with our present day ideas to realize the wonderful amount of original research that has been made. Harvey's was the decision that gave the impetus to later investigators. Among the latest and most important discoveries, which were made possible by the earlier physiologists, we might mention vaccination and antitoxims, two of the greatest life saving discoveries the world has ever known —more important than gun powder, diamonds, silver or gold.

Our knowledge of malaria, yellow fever, typhoid fever, their prevention, which is more important than their cure, is entirely due to physiology. While acknowledging the part bacteriology plays here, it must

be admitted that without physiology these discoveries would have been impossible. When one stops and reflects on the benefits of mankind accruing from physiology, I have no hesitancy in saying that it has done more to shape the destiny of the human race than all the wars, kings,queens, potentates now living or have lived.

A great part of the earth's surface now inhabited would have been hot beds of pestilence and disease—great tracts of land in Europe, part of Africa and Asia—our own southern states would have been ravaged by deadly Malaria, Cholera, Bubonic Plague, Yellow Fever, etc. The Panama Canal would be an impossibility. I say that Physiology is the foundation structure that has made these countries habitable and great enterprises possible.

If an army kills 200,000 men of the enemy's army or a naval commander destroys $65,000,000 worth of his antagonist's ships he is immediately proclaimed a great man; but how many outside of our own profession know anything of the men who have done some real service to humanity? Who knows anything of Reed, Carrol or Finley?

The physiology of respiration is very important. The necessity for the oxygenation of the blood and how it is accomplished. In the sixteenth century the Spanish threw all sorts of offensive matter including feces into the streets to purify the atmosphere. Nutrition is another important chapter. One has but to read a few chapters in any up to date physiology to realize the boundless good that accrues from a knowledge of this subject.

Physiology is divided into three great divisions: nutrition, innervation and reproduction. When we begin to consider innervation one stands appalled by the immensity of the subject. The physiology of the nervous system has been worked out with admirable precision during the last half century, with the single exception of the sympathetic system and our knowledge of that is increasing each year. The physiology of reproduction would fill a dozen larger volumes and much relative to it is not yet fully understood but its importance is evident.

To be a good physician, one must know the normal functions of the various organs and tissues of the healthy body and must be able to recognize deviations from the normal and to make practical application of the knowledge. Upon these facts and these alone the foundation of medicine rests and how can one know these things except physiology teach them?

It is my opinion that not nearly enough stress is put on the subject. After leaving college we are too apt to spend all our time and energy trying to find a specific for this disease or that symptom.

I quote from an original article by W. C. Abbott in the June Alkaloidal Clinic. After lambasting the Homeopath and Eclectics he says: "we

now turn the searchlight on the third of the so called schools, etc. The attention of the school has been largely engrossed by the study of physiology and pathology so that it has had little time to devote to the practical side of the profession—the work of treating the sick." A little farther on he says, "and he takes refuge in therapeutic nihilism, denying the possibility of favorably influencing disease by drugs, or he plunges into surgery or mechanical means discarding drugs. If he finds it necessary to use the latter, many people preferring drugs to being carved, he resorts to his prescription book and selects a formula, etc."

I am somewhat familiar with Dr. Abbott's methods and have admired him; but he only confines himself to the truth when it suits his purpose to do so. The so-called Allopaths have devoted considerable time and brains to the subject of physiology and pathology and had they not done so Dr. Abbot would occupy some other sphere no doubt from the one he now occupies. All other branches of regular medicine have advanced in spite of Dr. Abbott.

Is diptheria antitoxin, therapeutic nihilism? Is tetanus antitoxin therapeutic nihilism? Are the elaborate tubercular facts gleaned from pathologic works lost to humanity on account of theraputic nihilism or have they really done some good to the human race? Have the physiologic, pathologic and bacteriologic facts regarding yellow fever and malaria been of no benefit to mankind or should they be classed with therapeutic nihilism? The eminent doctors would make light of all advance in physiology or pathology but I assure him it is only a means to an end, and that the up to date Doctor of whatever school uses those drugs, which in the light of his teaching and experience have been of service in like cases. But the most important thing is to first make a diagnosis based upon a knowledge of physiology, and pathology, then apply the remedy or remedies that are indicated, whether they be alkaloids or the reliable tinctures or fluid extracts of such firms as P. D. & Co. or Lloyds.

I rather suspect that the so-called allopaths, who have lived, yes even died investigating such diseases as tuberculosis, cholera, bubonic plague, yellow fever, and malaria and gave freely of the result of their labors, have contributed more to the world than those who think that every one who doesn't look at things through glasses of the same degree of convexity as themselves are therapeutic, nihilists and carvers.

PUERPERAL SEPSIS—CAUSE AND TREATMENT.

J. J. SIPPY, M. D.,
Belle Plaine, Kansas.

Puerperal sepsis is according to each individual physician's experience an extremely rare(?) condition. At least he is as a rule extremely reluctant to confess the existence of such cases in his own practice, a course which would be in this age of commercialism, very unwise and inadvisable. The laity are quick to condemn and his competitors always ready to accuse him of his negligence to maintain strict asepsis and cleanliness, and any acquiescence on his part, or the absence of a ready denial, is accepted as a confession of his guilt, and his finances and reputation suffer in consequence. That the obstetrician may have followed all aseptic precaution or that his patient may have been guilty of gross neglect to maintain strict surgical cleanliness is no excuse. True though it may be that these thoughtless accusations are many times unjust, yet they have acted as factors in goading us to better educate ourselves in these conditions or forcing careful asepsis upon those of us who may be inclined to be careless either willfully or unguardedly. Yet at the same time they are for the most part harmful; for it is often the case that the physician is driven through fear of consequences to conceal facts and data which would prove invaluable in the study of these septic conditions. Still this condition of affairs is our own fault as physicians and educators in public hygiene, and while we may not for a great many years to come create among our clientage a thorough knowledge of bacteriology or the conditions which underly and produce these complications of the puerperium, yet we can and should disseminate a spirit of leniency for the practitioner who is earnestly striving for all that is good for his patient and himself.

Labor, while a physiological process, borders so closely upon the pathological that it is often indeterminable where the one stops and other begins. At any rate they may both be considered bacteriological. According to Edgar it is held that the cavity and contents of the gravid uterus are sterile in the majority of cases. In the minority a pre-existing endometris or one contracted during gravidity, from the death of fetus, or from some maternal blood infection, may bring about intrauterine infection. The claim that the vaginal secretion of a healthy woman whether pregnant or not, is normally sterile, and bactericidal, appears to be untenable, though it may be accepted as true in the ma-

jority of cases. It is readily agreed that the external genitals of a woman swarm with bacterial life, and contamination of the vagina may occur in many ways, especially during labor, when she is exposed to the introduction of outside germs through manipulation of the outside genitals, instrumental interference, bathing in tubs, the use of infected douche points, napkins, etc. What this germ may be can only be decided after careful laboratory investigation. Although in many cases the clinical picture may be diagnosed it is not infallible and is often misleading as far as treatment is concerned.

The common saphropytes which under ordinary circumstances prey only upon dead tissues may assume abnormal virulence and toxaemic properties and cause general infection unaided. The deadly streptococcus pyogenes sometimes exists as a harmless saprophyte, while under certain conditions it may simply set up local inflammation and toxæmia, and in its highest form of virulence is the chief cause of septicæmia. Gonorrhoea may occur as an active or of a latent type. I have had in my own practice an undoubted puerperal infection of tubercular origin, due no doubt to the migration of the bacilli from a large tubercular ulceration of the rectum, or possibly through the systemic infection of the blood. The infectious diseases such as erysipelas, diphtheria, scarlet fever, measles, etc., play their several parts in the etiology of this condition. However none of these may act singly, and it is rarely that any infection is of one type, purely and unaided. At any rate our treatment of the infection is directed towards the destruction of these germs and since this varies little in either case, an accurate bacteriological diagnosis is not nearly so important as is our recognition of the extent and result of the infection.

The focal lesions may take place from a vaginal ulcer, unhealed perinal tear, the tract of a suture, an unrepaired cervix or a general endometritis. Jewett, in the Brooklyn Journal for January, 1904, points out that the diagnosis must exclude non-septic infectious diseases and other than pelvic sources of septic infection. It should also be known whether the vagina or the uterus is the seat of the infectious focus. In nearly all cases the primary seat of infection is the uterine cavity. Infection may take place during labor or at any time during the puerperium. It has also been known to occur in women in which no examination had ever been made, proving conclusively that the germ is not necessarily always carried on the finger of the attending obstetrician.

Any rise of temperature or of any extent is to be watched with suspicion. Preceded by chill it increases in gravity. It has been held and is yet by a great many physicians that a rise of temperature may never occur without some infection of the genital tract, but nearly everyone

has seen well defined cases of auto-toxæmia, with fever, occur many times outside of pregnancy, why therefore can we not have it in the puerperium? The fatigue of the sympathetic nerve centres, induced by the process of labor, lacerations and other reflex conditions, are all productive of the most obstinate constipation, which in itself may cause the most severe toxæmia. In consequence we have fever, nausea, loss of appetite, slight delirium or stupor, flushed countenance, cessation of milk secretions, abdominal tenderness, etc., and yet how quickly this all disappears by a thorough flushing of the colon, and the administration of an active cathartic. Still, as I have said at first, any rise of temperature is always indicative of an infection, and the height of the infection is in direct proportion to the virulence of the infection. In a saprophytic or putrid endometritis, or what might be very properly termed a sapremia, we find this rise of temperature rarely occurring before the fourth or fifth day. Accompanied by a decided subinvolution, some tenderness of the fundus, with decided softening and flabbiness, sometimes pain, and occasionally free hemorrhage, a very offensive lochial discharge, frothy and light colored, and the toxæmic symptoms before mentioned, we have a decided picture of a saprophytic infection due to retained products whether membranous or placental shreds, blood clots, or sloughing of the endometrium. The complete cessation of the lochia at times, is due not to its "drying up," but rather to the mechanical obstruction of the uterine cavity either by shreds or malposition of the uterine body. The prognosis in this condition depends upon the prompt evacuation of the offending contents, the extent of metastatic infection and general condition of the patient.

A virulent streptococcus infection is unmistakable. The rise in temperature reaching as high as 106 to 107 degrees occurs within 48 hours and is as a rule abrupt and preceded by a most severe rigor, which may be repeated every 6 to 12 hours, and followed by a most severe prostration. Severe uterine pains and tenderness, with fixation and rigidity of the abdominal muscles, typical of pelvic inflammation, tympanites, retention of urine, or a highly acid urine, partial cessation of lochia which may or may not be offensive, vulval swelling and tenderness, an anxious expression of countenance, and rapid acceleration of pulse to a rate of 130 or uncountable in fatal cases, are all indicative of the severe inflammatory process, which is produced by this rapid bacterial migration.

Metastasis may occur with involvement of any or all pelvic organs and the consequent formation of pus cavities and abscesses, phlebitis, etc.

Systemic infection may be rapid and the patient overwhelmed

within a few hours. Prognosis depends upon general conditions of patient at outset, the absence of any organic disease, the general care and nursing and promptness of treatment.

Treatment in all cases is preventative, curative, and surgical. Preventative treatment is directed towards hygiene of patient, care of patient, physician and accessories. Hygienic treatment is directed towards building up the patient for resisting the infections, proper attention to room, light, drainage of the lying in house, etc.

Proper care of the patient is directed toward cleanliness, bathing, proper asepsis of the vulval pads, sheets, bedding, instruments used, etc. The use of the vaginal douche of weak bichloid or sterile water is recommended and used by a great many obstetricians but in my own practice I prefer to simply douche the external genitals, unless there should be an offensive lochia.

No physician who is attending any infections or contagious disease, or wound, should attend a case of confinement when it can be avoided. When he does it should be only after a complete bath and change of clothing, proper antiseptic care of hair and beard, and should never touch the patient without the hands encased in rubber gloves, properly sterilized. Curative treatment is directed toward support of patient and elimination of the infections. The method outlined by Jewett meets so heartily with my approval that I can, with a few alterations, do no better than outline it.

Membranous patches in the vagina may be treated with applications of tincture of iodine, or carbolic acid, followed immediately with alcohol and repeated two or three times daily, or may be dealt with after the method of Webster by vaginal packs of glycerinated formalin. I have found ichthyol diluted with fifty per cent sterilized water, and applied by brush or on a strip of gauze, very efficient. When the uterine cavity is the seat of infection the uterus should be explored to learn whether it contains fragments of placenta, or membranous or blood clots. Necrotic material can best be removed with the gloved finger and dressing forceps. Debris may be swept out with a soft cotton ball held in dressing forceps or by irrigating with normal salt solution. The foregoing manipulation should be conducted on a dressing table with due aseptic care. The dull curette is indorsed by many authorities and condemned by others. I have always used it as an exploratory measure at outset, and with due precaution I can see no contraindication to its use. Repeated curetting I do not endorse although some physicians repeat it several times, following it with a mop of tincture of iodine.

My favorite method of treatment after the exploration and removal

of debris is the repeated douching with sterile or normal salt solution, occasionally using a weak bichloid or creolin solution.

Jewett claims that eighty per cent of all streptococcic infections recover without treatment. On the other hand the most virulent infections will end fatally whatever treatment is employed. The temptation is to do too much.

The systemic treatment consists in bracing the resisting powers and in promoting elimination. For the former purpose strychnine and alcohol are the principal measures. Elimination is favored by one or two bowel evacuations daily and by diuresis. Plenty of water should be introduced into the circulation by the stomach by enteroclysis, of if necessary by hypdermoclysis. The addition of acetate of sodium to the fluid injected adds to the diuretic affect. Antipyresis when required may be effected by sponging or by wet sheet packs with water at a rapid or neutral temperature. Pus collection should be detected promptly and be dealt with as in other conditions.

IMPORTANT NOTICE.

Some months ago through the columns of the JOURNAL I requested the Councillors to make monthly reports of the conditions of the county societies in their respective districts. To this request Mr. Furst was the only councillor that responded, in which he stated that he organized Cowley County with an interesting meeting and that before the end of the year every county in his district would be organized.

I feel that my effort, to have the profession know the condition existing throughout the state, from these reports, has been a failure.

Now that I am at a loss to know just what would be the proper procedure, I have decided to call a meeting of the Councillors, and Secretary, on October 18, 1905, 10 a. m., at the Coates House, Kansas City, Mo. (This being perhaps, the most convenient place for all to reach.) and endeavor to arrive at some plan by which the organization may be brought to a higher plane and unite the profession in a social and scientific phalanx.

I have instructed the Secretary to give notice to each Councillor, and I hope to see every member of the Council present.

The editor of the JOURNAL will meet with us as he has some things of interest to present to the Council, whereby the JOURNAL may be made better, with the active support of the profession back of it.

Next year's meeting at Topeka, I predict will register the largest attendance in the history of the society. It will have a program that would be a credit to any State Society, one that will be so inviting that every active and scientific member of the profession in the state who is a lover of medical and surgical progress, will feel the necessity of making personal sacrifice to be present.

Our state possesses talent not to be ashamed of, and let us go on record, all together, as a unit.

As I am especially interested in the program for our next meeting, realizing upon it depends the success of the meeting, I wish to suggest in sending your "Subjects" to the Secretary, let it be done with the intention of presenting it to the Society in person, and not for free advertisement.

Also present your subject by Feb. 1, '06, so that a preliminary program may be iussued by the 10th.

The privilege to be on the program is extended to every member of the Society, so don't be too modest and wait for the Secretary to formally extend a pressing invitation, nor be disgruntled in the event the Secretary should fail to do so.

Sincerely and Fraternally,

CHAS. E. BOWERS,

President.

THE LAND OF THE FREE.

It is a splendid recognition that has come to Dr. William Osler in his appointment at Regius Professor of Medicine at Oxford University, but it robs us of America's leading physician. There is a feeling that he might have declined, as he declined other great honors, had it not been for a practice we Americans have of riding success too hard. It is strange to think of this great physician as a victim of the American "courtesy," habit, but that seems to be about the size of it. Doctor Osler is

"the doctor's doctor," and we read the following in an account of his recent appointment: "Not only local physicians, but many others from all parts of this country and Canada, consult him concerning their personal complaints. This part of his practice is unremunerative, as the usual courtesies extended by one member of the medical profession to another do not permit of the charging of a fee. Though the confidence of the fellow-members of the medical profession has been flattering to his abilities as a practitioner of medicine, it has, nevertheless, consumed a considerable portion of his time. Some of Doctor Osler's friends believe it has been an important factor in influencing him to make the change."

Doctor Osler's case is not exceptional. Every great specialist in America suffers, in a greater or less degree, from the same conditions. Professional courtesy drains him of both time and strength, and the larger his success the heavier the demands for free service.

America has been called the land of the free pass. Nowhere in the world does the free habit reach such excesses as in the United States. A close observer on a train, especially a handsome train, notices the large proportion of passes to purchased tickets. One of the costliest express trains in the East is called The Pass Unlimited.

Nor does it stop here. At this very time we are having a refreshing illustration of it in the operations of our Government. Millions of documents, weighing in the aggregate hundreds of tons, are being sent through the mails under Congressional franks when as a matter of common honesty, the campaign committees should be paying postage on them. One reason why our postal system does not turn into the treasury a large profit is the enormous amount of free business it carries.

Of course, there must come a time when reform will begin its work. The railroads are trying to cut down free passes. Business is aiming at courtesy reductions, but the progress is slow.

In some respects there may be a "quid pro quo" in the free habit, but when it can banish the country's foremost doctor and produce a deficit in a great monopoly like the postal service its weakness is evident.

In the end common-sense will prevail. Then, when all pay alike, those who have to pay will not have to pay so much, for under the free system the man who pays his own way has to pay the way of those who do not pay.—From the Saturday Evening Post.

Gift to Library.—Dr. Jacob Geiger, of St. Joseph, Mo., has presented to the library of the Medical Department of the St. Louis University a complete set of Virchow's archives, comprising of 170 volumes.

LIQUOR LICENSE FOR PATENT MEDICINE DEALERS.

The Commissioner of Internal Revenue has ordered that after December 1, any one who sells so-called "patent medicines" "composed chiefly of distilled spirits, or mixtures thereof, without the addition of drugs or medicinal ingredients in sufficient quantities to change materially the character of the alcoholic liquor," must be licensed as a retail liquor dealer. "The same ruling," says the Commissioners, "applies to every alcoholic compound labeled as a remedy for disease, and containing in addition to distilled spirits, only substances or ingredients which, however large their quantity, are not of a character to impart any medicinal quality to the compound." This additional statement seems to forestall manufacturers of such drugs from circumventing the ruling by adding comparatively harmless ingredients. Heretofore the sworn statement of a manufacturer has been accepted as the official description of the contents of each compound. Hereafter this will be supplanted by the independent analysis of the department chemists. This order will interfere seriously with the habits of those who, consciously or unconsciously have become habitual users of alcohol as the result of taking patent medicines. Such a case as that which recently came to our knowledge, in which a clergyman who called in a physician was discovered to be suffering from alcoholism through the use of a widely advertised proprietary article, will be rarer than it is. That clergyman would not have bought the stuff if he had to go to the licensed liquor dealer to get it. What is still more important, mothers who now give alcohol disguised in drug bottles to their children will have at least a chance of understanding better what they are doing. The practice of implanting in little children an appetite for alcohol and opiates is one which curses this land to an alarming extent. It creates annually no one knows how many habitual drunkards. The man who takes his whiskey over the open bar knows what he is doing; but the child to whom alcohol as an opiate is given is subjected to peril without knowing it. The manufacturers of these disguised stimulants and narcotics have, unfortunately, strong allies in a large part of the newspaper press, which finds their advertisements a source of great profit. City dailies, country weeklies, and denominational organs are about equally offenders against this aspect of the public welfare. We hope that the order of Commissioner Yerkes will shame the press into excluding from their columns advertisements of such articles and will help to arouse a healthy public opionion against the surreptitious use of stimulants.—From The Outlook.

THE MEDICAL RECORD AND THE PROPAGANDA AGAINST NOSTRUMS.

A little while ago the New York Medical Record contained a two-page advertisement of the Etna Chemical Company, which evidently was intended to counteract the effect of the report of the Council on Pharmacy and Chemistry which showed phenalgin to be a simple acetanilid mixture. Still more recently the same journal contained another page advertisement, one of which was occupied with a cartoon intended to cast ridicule on the efforts being made against the nostrum evil. Since these advertisements appeared in a scientific medical journal and a journal that is supposed to represent intelligent physicians, one might charitably suppose that they were admitted through lack of supervision. Such does not appear to be the case however.

Under date of September 8, the editor of The Journal of the American Medical Association sent the following letter to the Medical Record.

To the Editor:

Your issue of last week, September 2, contains a two-page advertisement of the Atna Chemical Company relating to their preparation, phenalgin. One page is entirely taken up with a cartoon evidently intended to deride The Journal of the American Chemical Association, the Council on Pharmacy and Chemistry of the American Association, and the progaganda against nostrums. The other page contains what is presumed to be an answer to the official announcement of the Committee on Chemistry regarding its investigation into certain preparations offered to the profession and to the public, especially as it is related to phenalgin. Permit me to quote from the advertisement as it appears on advertising page 21 of the Record:

"Recently certain ill-advised persons have attempted to confuse Phenalgin with patent and quack Nostrums and have so far succeeded that the influence of the Journal of the American Medical Association has been brought to bear against our legitimate and ethical business."

"We believe that Commercialism of the rankest kind has dominated this absurd crusade against us. These people may call Phenalgin a mixture or a compound, or anything that pleases them, it does not in the least change the fact that Phenalgin is just what we have always said it to be."

"We know that doctors who are practicing medicine and prescribing Phenalgin, will continue to do so regardless of the reports alleged analytical chemists whose experience in the sick room is an atom of a myth compared with that of those who are continually using our products."

My object in writing you is to briefly state certain facts solely for the information of your readers.

What the Council on Pharmacy and Chemistry of the American Medical Association is and what its functions are, is well known to your readers. While the council has been outlining plans for work, making investigation into various products,

it has published but one official report; this was on six preparations, viz: ammonol, antikamnia, Koehler's headache powders, orangeine, phenalgin and salacetin (sal. codeia Bell.) The report on phenalgin was as follows:

"According to the analysis of the contents of the original sealed packages as purchased, this was found to be a mixture, and to contain the following ingredients approximately in the proportions given:

Acetanilid	Sodium bicarb	Ammonium carb.
57	29	10

"Certain packages of phenalgin were purchased which on analysis did not show ammonium carbonate."

The committee signing the report * and vouching for its truthfullness consisted of:

J. H. Long, M. S., Sc. D., professor of chemistry in the Northwestern University Medical School and director of its chemical laboratories, the author of "A Text-book of Physiological Chemistry" and other works on chemistry, and, last year, president of the American Chemical Society."

W. A. Puckner, Ph. G., professor of chemistry in the school of Pharmacy of the University of Illinois and a contributor of scientific articles to chemical journals:

S. P. Sadtler, Ph. D., professor of chemistry in the Philadelphia College of Pharmacy, author of "A text Book on Chemistry," associate editor of the U. S. Dispensatory, and a member of the Committee on Revision of the U. S. Pharmacopeia.

Julius Stieglitz, Ph. D., professor of chemistry in the University of Chicago, a man of wide repute as a chemist, and the author of several works on shemistry, and

H. W. Wiley, M. D., Ph. D., chief of the Bureau of Chemistry of the Department of Agriculture, Washington, D. C.

Besides the above, other chemists assisted in the work, and the following made analyses of phenalgin:

E. M. Gordin, Ph. D. (Berne), professor of chemistry in the school of Pharmacy of the Northwestern University who has done a large amount of original work, as his contributions to chemical literature will show; and

Max D. Slimmer, B. S. M. A. (University of Chicago,) Ph. D. (Berlin,) who has several fellowships in chemistry in the University of Chicago, who has done considerable original work in chemistry, and who is recognized as an honorable and capable analytical and consulting chemist.

These are the gentlemen referred to in the advertisement in the Medical Record of "alleged analytical chemists."

In a former advertisement the Etna Chemical Company says: "We protest against the association of Phenalgin in that publication" (meaning The Journal of the American Medical Association) "with patent medicines and nostrums as an uncalled for insult to a reputable American Manufacturing Chemical Industry."

In this statement, the Etna Chemical Company gives physicians the right to ask whether it is "reputable" to inveigle them into prescribing a simple acetanilid mixture under the supposition that it is a definite synthetic chemical substance and to charge a dollar an ounce for a preparation the ingredients of which cost less than five cents.

There is, however, one assertion made in the advertisement which, I think, is well taken. The preparation is certainly not now a "secret remedy" for the Council on Pharmacy and Chemistry has cleared up all doubts at to the composition of "ammoniatedphenylacetamide,"

*The Journal A. M. A., June 3, 1905, p. 1791.

Since you did not see fit to publish or mention, the report referred to above, but have allowed your advertising pages to be used to slur the council on Pharmacy and Chemistry of the American Medical Association, as well as The Journal of the American Medical Association, I think it only fair to your readers that they be informed of the facts in the case, as far as they refer to phenalgin. I therefore, ask that you kindly publish this.

To the above the editor of the Medical Record replied under date of September 12.

It has always been the aim of the editor of the Medical Journal to keep the editorial and advertising pages of the journal entirely distinct and in continuing that policy I am forced regretfully to return your letter replying to an advertisement in the issue of September 2. If there should be at any time be anything in the reading pages of the Medical Journal Record relating to you or the Association whose interests you guard so well, to which you might take exceptions, I promise you the opportunity to reply fully and freely; but I am not responsible for what appears in the advertising pages, and can not open the correspondence department to letters in commendation of condemnation of anything appearing in that part of the journal. I regret the seeming discourtesy to you, but you surely can see to what abuses it might lead were correspondents permitted to discuss in the reading pages the statements made by advertisers.

THOMAS L. STEDMAN,

P. S.—If you publish this letter in your own journal or elsewhere, I trust you will, in justice to the Medical Record and to me, publish also this letter giving my reasons for refusing you the hospitality of our columns. T. L. S.

We are very glad to know that "the editorial and advertising pages of the Medical Record are entirely distinct." Since antikamnia, ammonal, phenalgin, and salacetin, in the form of sal-codeia—Bell, each occupies from a half to a page in the Record, some physicians were unkind enough to insinuate that this was the reason the editor totally ignored the report which exposed these preparations. Dr. Stedman's letter shows that this could not be, since the editorial and advertising departments are "entirely distinct."—From the Journal of the A. M. A. for Sept. 23, 1905.

NEWS ITEMS.

Hospital Dedicated.—St. Mary's Hospital, Winfield, was formally dedicated September 3 by Bishop Hennessy of Wichita, The hospital has thirty rooms and is equipped with modern conveniences and appliances.

Dr. D. W. Manson, Burlington, left on August 28 for Central America.

The following have joined the A. M. A. since our last report: Cas well, C. E., Wichita; Leverich, L. Solomon; Ross, H. R., Sterling; Walker, O. D., Salina; .

Albert Isaacson, M. D. (Examination Kansas), died at his home in McPherson, Kansas, from congestion of the brain, August 20, after an illness of a few hours, aged 31.

Eugene William Dickinson, M. D. St. Louis, 1891, formerly an attendant at the Topeka State Hospital, died in Topeka, Kansas, September 6, after an illness of fourteen hours, from apoplexy, aged 33.

Dr. F. M. Owens of Argonia is doing a few weeks of post graduate work in the Clinical School of the University of Kansas. The doctor is doing special work in surgery with Gray, Steman, Robinson, Hughes, Griffith, and W. J. Frick.

Southwestern Tri-State Medical Association will meet in Oklahoma City, November 8 and 9. Railroads rate, one fare plus 50 cents. First class hotel facilities. The association covers Texas, Indian Territory, and Oklahoma. Drs. Glasscock and Hoxie of our society are scheduled to be present.

Fever in State Hospital.—Typhoid fever has developed at the Topeka state Hospital for the insane. Five employees and one inmate are ill with the disease. The superintendent believes that the ice supply of the institution, which is obtained from the Kansas River, is responsible for the epidemic.

The American Surgical Association at its recent meeting in San Francisco elected the following officers: President, A. Vander Veer, Albany, N. Y.; vice president, J. E. Moore, Minneapolis; J. C. Munro, Boston,; secretary, D. P. Allen, Cleveland; treasurer, Geo. R. Fowler, Brooklyn; recorder, R. H. Harbe, Philadelphia; The next meeting will be held at Cleveland

First District.—The fall meeting of the First District Society will be held in Leavenworth October 12th. The occasion will meet in the Evergreen Place Hospital beginning at 2:00 and 7:30. Papers have been promised by the following: Drs. P. D. Hughes, president, Z. Nason, Stewart Mckee, O. P. Davis, T. W. Peer, E. J. Shelly, H. H. Smith, C. A. Libby, M. A. Barber, C. C. Goddard, councillor, J. P. Blunk, J. E. Hunt, F. F. Greene, A. B. Tonkin.

The **Salina County Medical** Society met in regular session on September 7 at Salina, Kansas. The program: The improper use of the word Typhoid, purposely or through neglect, Dr. W. H. Winterbotham, Salina. Hernia, Dr. J. R. Crawford, Salina. Paper, Dr. E. W. Hawthorne, Gypsum. Suggestion, Dr. N. D. Tobey, Salina. The first paper being an interesting subject and so thoroughly presented, resulted in a very extended discussion and it was voted to hold an adjourned session of the meeting the following Thursday night, at which time the remaining papers of the program were presented. A banquet followed the meeting. Applications for six new members was presented, Drs. W. E. Fowler, Brooksville; M. J. Brown, Salina; O. D. Walker, Salina; J. A. Simpson, Salina; C. D. Armstrong, Salina; E. J. Lutz, Salina; leaving but five active practitioners in the county who have not made application for membership.

H. N. Moses, Secy.

Another Merger.—September 1st, 1905, by the unanimous action of their respective Boards of Trustees, assembled in Indianapolis, the Medical College of Inidana was made the Medical Department of Purdue University, with the title of Indiana College Medical, The School of Medicine of Purdue University. The Medical College of Indiana was founded in October, 1869 and has given continuous instruction in Indianapolis for the thirty-five succeeding years. It has graduated over 1600 students, has some three score teachers and unexcelled clinical facilities. These include the Bobbs Free Dispensary in the College building, where 15,000 cases are treated annually and used for daily clinical teaching in seven different sections; also, the City Hospital with 200 beds utilized for morning bedside clinics; St. Vincent's Hospital, in which the college maintains public wards for clinical teaching; the City Dispensary, and the Central Hospital for the Insane where clinical courses of nervous diseases are held. The properties of the college worth $100,000, the alumni list, the student body of 270 students, the history and traditions of the college are all now merged in and are now an integral part of Purdue University, the leading professional school of Inidiana, and subject to its governing body. For the first time in the history of medical education in Indiana, its pioneer medical school has formed a university union, which makes it an integral part of the State System of Education in the same way and manner that the Medical Department of the University of Michigan is related to the State System. For the present year the functions of the Medical College will be carried on exactly as indicated in the 36th Annual Catalogue already issued and distributed. The college will remain permanently in Indianapolis, the place of its origin and development, a city presenting the clinical material required for a modern school of practical medicine.

CORRESPONDENCE.

Topeka, September 27, 1905.

TO THE EDITOR:

We have forwarded to your new address a copy of our September bulletin. I would be glad if you would take the time to read that portion of the bulletin concerning the transmission of typhoid fever, this being but a brief abstract from the advance sheet of the conference of state and provincial boards of health with the U. S. Public Health and Marince Hospital Service, and as published in their bulletin has the official sanction of the Government. You will notice that quite an advanced step has been taken concerning the sanitary features of typhoid fever, that is to say this conference put themselves on record as insisting that thorough disinfection of the house, bedding, clothing, and other things, should be practiced after cases of typhiod the same as other contagious or infectious diseases. As this attitude is somewhat in advance of what our sanitary views have been heretofore, I would be glad if you would publish that portion of our bulletin in full, with comments by yourself concerning the urgent importance of disinfecting in typhoid fever. I believe that a great step in advance in the prevention of this dread disease will have been taken when such practice will become the routine requirement the same as in cases of smallpox. I am therefore anxious that this aritcle should have the widest publication. Will you be so good as to forward me a copy of your journal when you publish the article.

S. J. CRUMBINE, Secretary.

Colorado's New Medical Law.—The new State Board of Medical Examiners meets this month to formulate the necessary rules, and put into complete operation the new State Medical Law. It is a significant fact that the only important opposition to the signing of the law by the Governor came from the representatives of the newspapers, and was frankly based on the ground that it would injure the State by lessening their receipts from the patronage of advertising quacks. In one of the newspapers the law is spoken of at "a so-called medical bill that will cause $150,000 a year to be sent to advertising specialists outside of the state of Colorado." In other words the people of Colorado will be compelled to go outside of the State in order to be fleeced in this particular manner. This may be ture. But with their present gambling facilities, fake mining schemes and promoters generally, they will probably be able to part with their money fast enough; and the public health will be all the better for it.—From Colorado Medicine.

STATE BOARD QUESTIONS.

OPHTHALMOLOGY, OTOLOGY, RHINOLOGY, AND MEDICAL JURISPRUDENCE.

April 25, 1905.

1, Describe and prescribe for an ordinary case of chronic rhinitis. 2, Name some constitutional causes of epistaxis. 3, Name five diagnostic symptoms by which you may differentiate between acute conjunctivitis and acute iritis. 4, Define the following terms: Trachoma, blepharitis, pterygium, trichiasis, entropion, cataract. 5, Describe a case of otitis media purulenta. 6, Treatment of same. 7, Define medical jurisprudence. 8, State the difference between a burn upon the body made before, or after, death. 9, Differentiate the term abortion from miscarriage.

PHYSIOLOGY.

July 12, 1904.

1, (a) Give the normal pulse rate; (b) respiratory rate; (c) What influences may change these? 2, What histological element of the kidney secretes urine? 3, Name four elementary tissues that are essential to any movable joint and give the function of each. 4, What becomes of the bile after it is secreted by the hepatic cells? 5, Describe the pleura, giving the kinds of tissues, and its functions. 6, (a) Describe the mechanism of respiration. (b) Show the benefits derived from deep inspiration. 7, What are the functions of bile? Give its composition. 8, (a) Describe the nature of the perspiration. (b) Compare its elimination with the other eliminants. 9, What is meant by the "vaso-motor system?" How is its action modified? 10, Describe the digestion of (a) milk, (b) vegetables, (c) oils and (d) meats.

October 11, 1904.

1, Give the composition of human blood in normal condition. 2, Describe the fetal circulation. 3, Give the entire process of digestion, beginning with mastication (a) of albuminous food; (b) of fatty food; (c) of starchy food. 4, Name all the veins which have no valves and give reason why. 5, Describe the sympathetic nervous system; what are its functions? 6, What centers are located in the medulla oblongata? 7, Name all the ductless glands of the body. Do they form secretions? 8, Describe the mechanism and circulation of the blood through the heart

and explain the diastolic and systolic action. 9, Give process by which nourishment is appropriated for repair. 10, Describe the entire process of deglutition.

April 25, 1905.

1, (a) Describe the capillary circulation. (b) How influenced and controlled? 2, Name four great classes into which foodstuffs are divided. 3, (a) To which class of foodstuffs does milk belong? (b) Describe its digestion and tell where it takes place. 4, (a) Desrbie the saliva. (b) What is its chief purpose? 5, What is meant by the nervous mechanism of respiration? Is breathing a voluntary act? 6, (a) What effect has blood pressure up on the flow of urine? (b) Name a remedy that will act as a diuretic in this matter. 7, What is the function of the serous membrane and where found? 8, What do you understand by the term "shock." 9, What are the influences regulating or modifiying the beat of the heart? 10, Describe the process of digestion, beginning with mastication, and tell what fluids are supplied to the food during its course through the alimentary canal and where each is derived from .

BACTERIOLOGY.

April 25, 1905.

1, What are the essential factors in infective processes; (b) And the different kinds and names of bacteria that cause them? 2, (a) Describe the technique of Widal's reaction. (b) Give its diagnostic value. (c) Give microscopic reaction of Widal's test. 3, What ways do persons become infected with tubercular bacilli? 4, What are and give a brief description of each: (a) Alexins. (b) Leucomains. (c) Lysins. (d) Agglutins? (e) Yeast? 5, What is Lustgarten's bacillus? Describe the parasites of tertian and quartian ague. 6, How do bacteria produce disease, and give the methods and theory of destreution of bacteria in the body? 7, How would you examine milk for tubercle bacillus, and what bacteria are liable to be confounded with them? 8, Give the origin, composition, formation of bacteria and cell contents. 9, Give the character of the bacillus of influenza; also of pneumonia. 10, Give methods of staining bacteria; (a) making culture media; and what kinds of media have we?

July 12, 1904.

1, What do you understand by protective inoculation? 2, What do you understand by pathogenic organisms? 3, What do you understand by attenuated germs? 4, What do you understand by traumatic infection? 5, Name several modes of infection. 6, What is antitoxin of diphteheria? 7, Name two of the most common pus-producing micrococci.

8, How do bacteria mulitply? 9, What are the etiological relations of micro-organisms to septico-pyemia? 10, Name five agents, in comparative value, for the destruction of germs external to the bodies of living animals.

October 11, 1904.

1, What are bacteria and how do they multiply, and what is their shape? 2, What is essential to the life of bacteria? 3, What are the most favorable media for the development of bacteria? 4, What is sterilization and what kinds have we? What are antiseptics, and name several? 5, Define immunity. 6, Name the various forms of culture media used. 7, Name the malarial parasite and describe it. 8, Give the names of the bacillus of typhoid fever, gonorrhea, and diphtheria. 9, Describe the bacillus anthrax. 10, What disease do we find micrococcus lanceolatus?

PATHOLOGY.

April 25, 1905.

1, (a) What is oedema? (b) Give causes of the oedema of passive hyperaemia; (c) of the oedema of cachexia, (d) and of malignant oedema. 2, Give pathological lesions which may result from syphilitic or rheumatic iritis. 3, Define osteomyelitis and give causes for same. 4, Give pathological lesions that take place in infantile spinal paralysis. 5, Give pathological lesions and differentiate between acute malignant and chronic endocarditis. 6, Define and give pathological lesions of cerebral hemorrhage. 7, How would you recognize cerebral spinal fluid, and how would you test it in tubercular meningitis? 8, Describe the appearance of the pleura in different stages of pleuritis. 9, Define gastric ulcer and give pathological lesions. 10, Differentiate between acute gastric catarrh and acute toxic gastritis and pathological lesions of each.

July 12, 1904.

1, Define multiple neuritis and give its etiology and symptoms. 2, Define croupous pneumonia and give etiology and pathological anatomy. 3, Give the pathological difference between yellow atrophy and amyloid and the atrophic cirrhosis of the liver. 4, Give the pathology of pigmentary retinitis. 5, Give the pathology of retro-bulbar neuritis. 6, Describe the pathology of acute proctitis. 7, Describe in detail the pathological anatomy of gonorrheal orchitis. 8, Give the pathology of scorbutus. 9, Give the pathology of rhachitis. 10, Give the pathology of osteo-periostitis.

October 11, 1904.

1, Give the pathological anatomy of herpes zoster. 2, Describe the

pathological changes in Graves' disease. 3, Describe the pathological changes in Meniere's disease. 4, Describe the changes in acute peritonitis. 5, Describe the detail the changes that take place in a typhoid ulcer. 6, Describe pathological changes in acute pulmonary consumption. 7, Describe morbid changes in chronic cystitis. 8, Describe morbid anatomy in case of advanced rachitis. 9, Describe changes in purpura hemorrhagica. 10, Describe changes that may take place in the heart during an attack of acute articular rheumatism.

OBSTETRICS AND GYNECOLOGY.

April 25, 1905.

1, Write one page on the induction of artificial labor. 2, How to treat hemorrhage after delivery? 3, Name some of the diseases of pregnancy. 4, Name as many presentations in labor as you can. 5, Give treatment for four presentations in labor. 6, Puerperal eclampsia—diagnosis and treatment. 7, Give dislocations of the uterus. 8, Name four diseases of the ovaries and give treatment. 9, Name five diseases of the vagina. Give treatment. 10, Name a few of the new formations of the uterus.

July 12, 1904.

1, What are the indications for the use of forceps? 2, Conditions requisite for the application of the forceps. 3, Under what conditions would you induce premature labor? 4, What is version? How many kinds are there? Name them. 5, How would you perform each kind of version? 6, How would you treat tumors of the mammary glands in a general way? 7, Give diagnosis, prognosis, and treatment of fibroids of the uterus. 8, Give the use of the curette. 9, Give the use of the tampon. 10, How would you treat a case of peurperal eclampsia?

October 11, 1904.

1, Give diagnosis and treatment of placenta previa. 2, State principal causes of puerperal infection. 3, State causes and treatment of afterpains. 4, Is abortion ever justifiable? If so, when? 5, Give probable cause and treatment of mammitis. 6, What is amenorrhea? What is menorrhagia? 7, Give treatment. 8, What is tubal pregnancy? 9, By what method would you treat a complete laceration of the perineum? 10, Define metritis and give treatment.

CHEMISTRY.

April 25, 1905.

1, Give the subdivisions of a meter and how much is one liter? 2, In the electrolysis of tumors, what needle should be inserted into them; which

in aneurisms, and why? 3, What is the hydrogen compound of sulfur, its properties? 4, Which is the most common poisonous compound of As? 5, How does CO act as a poison? 6, What is the action of KOH on the tissues, and to what class of poisons does it belong? 7, What are the antidotes for poisoning by the alkaline caustics? 8, Which are the two oxides of mercury? 9, What is the antidote for acute poisoning by Hg Cl 2? 10, Give either Moore's or Trommer's test for sugar in urine.

July 12, 1904.

1, What is the chlorin compound of sodium? 2, Where and how is K formed? 3, What are the antidotes for poisoning by HCl. 4, What is a volt? 5, From what source may chronic plumbism arise? 6, What is the difference in action of the "ous" and "ic" compounds of Hg? 7, What is the antidote for acute poisoning by Hg Cl 2? 8, What is bismuth generally contaminated with? 9, When is butyric acid present in the in the stomach? 10, What is the solubility of uric acid?

October 11, 1904.

1, What is galvanism? 2, How can it be demonstrated that hydrogen is lighter than air? 3, What is analysis and what is synthesis? 4, What is the effect of inhaling air rich with ozone on the respiratory organs? 5, In what manner does arsenic prove poisonous? 6, How does CO act as a poison? 7, What is the action of KOH on the tissues? 8, What is the antidote for acute poisoning by Hg Cl 2? 9, What is the reaction of blood during gout? 10, What is Trommer's test for sugar in urine.

ANATOMY.

July 12, 1904.

1, Give the anatomy of the heart. 2, Name and number the tarsal bones. 3, How many hones in the human skeleton? 4, Name the bones of the skull, including the face. 5, Give the anatomy of the liver. 6 What structures are divided in operating on an oblique inguinal hernia? 7, Bound Scarpa's Triangle, naming the floor, and the vessels and nerves found within this space. 8, Give names, origin, and distribution of the tenth cranial nerves. 9, Name structures divided in amputation of the middle third of the leg. 10, Name the carpal bones.

October 11, 1904.

1, Give the origin of the common iliac artery. 2, Name the muscles between the hip and knee. 3, Give the anatomy of the kidneys. 4, Describe the fetal circulation. 5, Give the distribution of the jugular veins. 6, Describe the origin and insertion of the pectoralis minor muscle; also

the psoas magnus and psoas parvus. 7, Describe the shoulder joints, giving articular surfaces, ligaments, etc. 8, Name all the bones of the hands and wrist. 9, What veins have no valves and why? 10, How many bones in the human anatomy? Why do anatomists differ as to the number?

MEDICAL JOURNALS WANTED.

The School of Medicine (Clinical Department) of the University of Kansas is trying to build up a reference library and therefore seeks contributions of back numbers of the standard medical journals, such as The Journal of the A. M. A., Medical News, Philadelphia Medical Journal, Medical Record, N. Y. Medical Journal, American Medicine, old transactions of gynecological, obstetrical and other special departments of medicine, etc. Physicians who desire to contribute to this library may send their contributions by express, collect, to the Simpson Block, Kansas City, Kansas.

"The chief reason why Tongaline is such an efficient agent in the treatment of rheumatism, neuralgia, grippe, gout, headache, sciatica and lumbago, arises from the fact that all these salicylic acid it contains is made from the purest oil natural of wintergreen. Hence the patient can take a sufficient quantity of this valuable drug to get its full therapeutic effects, which cannot be done with the synthetic product as the organs of digestion and assimilation will invariably rebel against the salicylic acid made from coal tar before the system is thoroughly under its influence."

For Sale.—Several microscopes suitable for general practitioners. In good working condition. Will sell at a bargain. Dr. F. J. Hall, Simpson Block, Kansas City, Kansas.

Important Notice.—Judging from communications recently received our reference to the "stegomyia fasciata" in connection with the "stegomyia punctata" has caused some physicians to suppose that we recommended Tongaline for yellow fever. This we emphatically disclaim. The mention of these two species of mosquitoes was for the purpose of indicating that the mode of inoculation of yellow fever and malaria was precisely the same, and a careful reading to our statement will show that we had no intention to suggest that Tongaline was indicated in yellow fever, but on account of its pronounced eliminative action it did possess decided therapeutic value in the treatment of malaria. We regret exceedingly that the notice referred to should have been misunderstood misconstrued by anybody.

MELLIER DRUG COMPANY,
St. Louis.